DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDI	CAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	00	CO					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G392	B. WIN			09/30/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	EST MAIN ST		
CARDINA	AL SERVICES INC	OF INDIANA		SILVER LAKE, IN46982			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0000							
			-				
			W	0000			
	This visit was for the pre-determined full						
	recertification an	nd state licensure survey.					
		d in Immediate Jeopardy					
		2 and W318 which were					
	not removed.	and the terminal training					
	not removed.						
	D-4 C	S					
	Dates of survey: September 26, 27, 28,						
	29, and 30, 2011	•					
	Surveyor: Susan	Eakright, Medical					
	Surveyor III/QM	IRP.					
	· ·						
	Provider Number	r: 15G392					
	Facility Number:						
	AIM Number: 1						
	Alivi Nullibel. 1	00233160					
	Those fodomol do	ficiencies also reflect					
	_	accordance with 460 IAC					
	9.						
	_ ~	completed 10/3/11 by					
	Ruth Shackelford	d, Medical Surveyor III.					
*****	Th - f97	and the state of t					
W0102	-	ensure that specific					
	governing body ar requirements are i						
	requirements are i	mot.	137	0102	W102 The facility must ensu	ıre	10/10/2011
	Događ oz zbasa	otion monord mariana and	"	0102	that specific governing body		10/10/2011
		ation, record review, and			management requirements a		
	interview, the Co	ondition of Participation:			met. Cardinal Services, Inc		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000906

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G392	B. WIN	G		09/30/2011
NAME OF	PROVIDER OR SUPPLIER	<del>"</del> }		1	ADDRESS, CITY, STATE, ZIP CODE	•
				1	EST MAIN ST	
CARDIN	AL SERVICES INC	OF INDIANA		SILVER	R LAKE, IN46982	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Governing Body and Management was				strives to meet and be in compliance with all of the	
	not met as the governing body failed to				conditions of participation	
		ng direction over the			established by the Secretary	of
	· ·	the Condition of			Health and Human Services	. This
		ient Protections was met			allegation of compliance is	
	for 8 of 8 clients	(clients #1, #2, #3, #4,			intended to show Cardinal Services' commitment to qua	ality
	#5, #6, #7, and #	(8); and to ensure the			delivery of services. Proact	
	Condition of Par	ticipation: Health Care			strategies and corrective act	
	Services was me	et for 3 of 8 clients (clients			will be developed as needed	<b> </b>
	#1, #3, and #7).	The governing body			avoid further incidents. It is	<b>I</b>
	failed to ensure implementation of the				Cardinal Services' belief that corrective action taken by	tine
	agency's policy and procedure for abuse, neglect, and mistreatment prevention, and				management staff and the Q	DP
					has resolved the Immediate	
	"	the facility immediately			Jeopardy created in the full	
		ts of abuse, neglect,			recertification survey dated	
	1 -	d injuries of unknown			September 26, 27, 28, 29 an	
	•	erning body failed to			2011. The following citations POAs will be monitored by the	<b> </b>
	"	ntation of effective			governing body to ensure fol	<b> </b>
		to protect clients from			up and compliance is in plac	e.
					Please see W104 Please se	ee
		ion, allegations of abuse,			W122 Please see W318	
	1	nistreatment systemically.				
		ody failed to provide				
	'	tht of the group home to				
	1	ghts, staff retraining, and				
	medication admi	nistration.				
	F: 1: . 1 1					
	Findings include	:				
	Please see W104	I. The governing body				
		0 0 3				
	failed to ensure implementation of their					
	policy and procedures for 1 of 2 clients					
	(client #5) who demonstrated PICA					
	(eating inedible items) behavior. The					
	governing body	failed to ensure client #5				
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	SZLC11	Facility 1	ID: 000906 If continuation s	heet Page 2 of 41

NAME OF P	(EACH DEFICIENCE REGULATORY OR IT WAS provided sufferement the identity	OF INDIANA  TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	PR	STREET A	DDRESS, CITY, STATE, ZIP CODE ST MAIN ST LAKE, IN46982	COMPLI 09/30/20	
CARDINA (X4) ID PREFIX	SUMMARY ST (EACH DEFICIENC REGULATORY OR I was provided suf- prevent the identi	OF INDIANA  TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	B. WING	STREET A 308 WE SILVER	ST MAIN ST	09/30/20	011
CARDINA (X4) ID PREFIX	SUMMARY ST (EACH DEFICIENC REGULATORY OR I was provided suf- prevent the identi	OF INDIANA  TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	PR	308 WE SILVER	ST MAIN ST		
CARDINA (X4) ID PREFIX	SUMMARY ST (EACH DEFICIENC REGULATORY OR I was provided suf- prevent the identi	OF INDIANA  TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	PR	SILVER			
(X4) ID PREFIX	SUMMARY ST (EACH DEFICIENC REGULATORY OR I was provided suf- prevent the identi	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR		LAKE, IN46982		
PREFIX	(EACH DEFICIENCE REGULATORY OR IT WAS provided sufferement the identity	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID			
	was provided suf- prevent the identi	LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD)			(X5)
TAG	was provided suf- prevent the identi				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
	prevent the identi		<u> </u>	TAG	DEFICIENCY)	•	DATE
	_	•					
	failed to ensure the	prevent the identified PICA behavior and					
		failed to ensure the facility implemented					
	effective action to address the PICA						
	_	overning body neglected					
	_	olicy and procedures for 8					
	of 8 clients (clients #1, #2, #3, #4, #5, #6,						
	#7, and #8) who lived in the group home,						
	to immediately report and investigate						
	client #1's unknown bruises identified on						
	9/26/11, and to develop interventions to						
	protect clients #1, #2, #3, #4, #5, #6, #7,						
	and #8 from clien	nt #3 and #8's potential					
	for physical aggre	ession.					
		122. The governing					
	_	eet the Condition of					
	Participation: Cl	ient Protections, for 1 of					
	2 clients (client #	5) who had PICA (eating					
	inedible items) be	ehavior. The facility					
	neglected to deve	elop and implement					
	effective interven	ations to protect the client					
	and to ensure suf	ficient supervision of					
	client #5 to addre	ess the identified PICA					
	behavior. The go	verning body neglected					
	to follow their po	olicy and procedures for 8					
	of 8 clients (clien	ats #1, #2, #3, #4, #5, #6,					
	#7, and #8) who l	lived in the group home,					
	to immediately re	eport and investigate					
	_	wn bruises identified on					
	9/26/11, and to de	evelop interventions to					
		•					
	_						
	for physical aggre	-					
	protect clients #1 and #8 from clien	, #2, #3, #4, #5, #6, #7, nt #3 and #8's potential					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G392		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE COMPI 09/30/2	LETED	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE EST MAIN ST R LAKE, IN46982		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
W0104	body failed to me Participation: He governing body the health care monit services and over administration for #1, #3, and #7) with medication errors.  9-3-1(a)  The governing body policy, budget, and the facility.  Based on observatinterview, the governing body ensure implement procedures for 1 who demonstrate items) behavior. failed to ensure consufficient supervidentified PICA tensure the facility action to address governing body implementation of procedure for about the supervision of the procedure for about the procedure for about the procedure for about the procedure for about the supervision of the procedure for about the proce	dy must exercise general doperating direction over ation, record review, and verning body failed to station of their policy and of 2 clients (client #5) and PICA (eating inedible The governing body client #5 was provided ision to prevent the behavior and failed to y implemented effective the PICA behavior. The failed to ensure of the agency's policy and	W0104	W104 The governing bo exercise general policy, the and operating direction of facility. Cardinal Services strives to meet and be in compliance with all of the conditions of participation established by the Secret Health and Human Services allegation of compliance intended to show Cardinal Services' commitment to delivery of services. Prostrategies and corrective will be developed as nee avoid further incidents. Cardinal Services' belief corrective action taken by management staff and the has resolved the Immedia	oudget ever the es, Inc. et atary of ces. This is al quality eactive action ded to lt is that the y e QDP	10/10/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G392	A. BUI	LDING	00	09/30/2011
		130392	B. WIN		PRESIDENT OF THE CORP.	09/30/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
CARDINA	AL SERVICES INC	OF INDIANA		1	2 LAKE, IN46982	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	Jeopardy created in the full	DATE
	' ' ' ' '	7 and #8), and failed to			recertification survey dated	
	ensure the facility immediately reported incidents of abuse, neglect, mistreatment,				September 26, 27, 28, 29 an	d 30,
					2011. The following citations	
	l -	nknown origin. The			POAs will be monitored by the governing body to ensure fol	II
	governing body failed to ensure				up and compliance is in plac	
	implementation of effective corrective action to protect clients from physical				Please see W149 Please se	ee
	aggression, allegations of abuse, neglect, and/or mistreatment systemically. The governing body failed to provide systemic oversight of the group home to ensure				W153 Please see W157 Please w331	ease
					355 MAG 1	
	clients' rights, staff retraining, and medication administration.					
	Findings include	:				
	Please see W149	. The governing body				
		ow their policy and				
	"	of 2 clients (client #5)				
	1 ^	ed PICA (eating inedible				
		The facility neglected to				
	provide sufficien	t supervision of client #5				
	to prevent the ide	entified PICA behavior				
	and neglected to	implement effective				
	action to address	the PICA behavior.				
	-	ody neglected to follow				
		procedures for 8 of 8				
	· · · · · · · · · · · · · · · · · · ·	1, #2, #3, #4, #5, #6, #7,				
	l '	d in the group home, to				
		ort and investigate client				
		uises identified on				
	9/26/11 and to de	evelop interventions to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G392			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE S COMPL	ETED	
		15G392	B. WIN			09/30/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	AL SERVICES INC	of Indiana		SILVER	LAKE, IN46982		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
		, #2, #3, #4, #5, #6, #7,					
	_	nt #3 and #8's potential					
	for physical aggression.						
		. The governing body					
	failed for 1 of 1 unknown injury observed (client #1), to immediately report client						
	#1's hand bruise to the administrator and						
	to BDDS (Bureau of Developmental						
	Disability Services) in accordance with state law.						
	Please see W157. The governing body						
		ent effective corrective					
	•	clients (client #5) who					
		CA (eating inedible					
	items) behavior.						
		. The governing body					
		operating direction over					
	-	sing services to provide					
	_	care monitoring and					
	_	ication administration for					
	·	ents #1, #3, and #7) with					
	significant medic	cation errors.					
	9-3-1(a)						
	, , , , (u)						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G392	A. BUILDING	00	COMPLETED 09/30/2011
		130392	B. WING		09/30/2011
NAME OF F	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE EST MAIN ST	
	AL SERVICES INC	-		R LAKE, IN46982	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG W0122	The facility must en protections required review, the facility of Participation: Client (client #5) who had behavior. The facility implement effective client and to ensure the #5 to address the idea. This noncompliance JEOPARDY. The irridentified on 9/27/11 jeopardy began on 8 neglected to implement procedure for abuse, The facility staff neglected to implement identified in the facility staff neglected to develocorrective intervention and from her identified in staff failed to develocorrective intervention continued PICA behavioral PICA behavioral mediate Jeopardy. During monitoring convenient of the program room in t	Insure that specific client ements are met.  In, interview, and record failed to meet the Condition of the Protections, for 1 of 2 clients PICA (eating inedible items) by neglected to develop and interventions to protect the sufficient supervision of client entified PICA behavior.  In resulted in an IMMEDIATE mediate jeopardy was at at 9:10am. The immediate jeopardy was at at 9:10am. The immediate jeotect and mistreatment, glected to provide effective at failed to protect client #5 PICA behavior. The facility spand implement effective ons to address client #5's avior. The Agency's ator (RC) was notified of the on 9/27/11 at 9:10am.  Subservations at the facility on 9/28/11 from 12:15pm until as observed to sit on the floor at licked a magazine, chewed a pages of a magazine, licked	W0122	W122 The facility must ensuthat specific client protection requirements are met. Card Services, Inc. strives to mee be in compliance with all of tonditions of participation established by the Secretary Health and Human Services allegation of compliance is intended to show Cardinal Services' commitment to quadelivery of services. Proact strategies and corrective act will be developed as needed avoid further incidents. It is Cardinal Services' belief that corrective action taken by management staff and the Chas resolved the Immediate Jeopardy created in the full recertification survey dated September 26, 27, 28, 29 ar 2011. The following citations POAs will be monitored by the governing body to ensure for up and compliance is in place Please see W149 Please see W157	are 10/10/2011 s dinal t and he of This lality ive ion I to t the DDP and 30, with he allow se.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G392		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMP: 09/30/2	LETED
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC		308 WE	ADDRESS, CITY, STATE, ZIP COI EST MAIN ST R LAKE, IN46982	E	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
her nose with her to and ate the lint. Clie redirected each time Immediate Jeopardy.  Based on observation review, the facility and procedures for the state of t	ngue, picked lint from the floor ent #5 was not observed to be by facility staff. The was not removed.  on, interview, and record neglected to follow their policy 8 of 8 clients (clients #1, #2, nd #8) who lived in the group by report client #1's unknown in 9/26/11, and to develop tect clients #1, #2, #3, #4, #5, client #3 and #8's potential for individual procedures for 1 of 2 or address the identified PICA in the procedure of the provide revision of client #5 and to be action to prevent client #5's interpretation of the procedure of the procedure of the procedure of the provide revision of client #5 and to be action to prevent client #1, #7, and #8) who lived in the inediately report client #1's centified on 9/26/11 and to the protect clients #1, #2, #3, #8 from client #3 and #8's all aggression.  3. The facility failed to client #1's hand bruise to the	TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G392 09/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 308 WEST MAIN ST CARDINAL SERVICES INC OF INDIANA SILVER LAKE, IN46982 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE implement effective corrective action for 1 of 2 clients (client #5) who demonstrated PICA (eating inedible items) behavior. 9-3-2(a)W0137 The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothina. W137 The facility must ensure W0137 10/10/2011 the rights of all clients. Therefore, Based on observation, record review, and the facility must ensure that interview, for 4 of 4 sample clients (clients #1, #2, clients have the right to retain and #3, and #4) and for 3 additional clients (clients #6, use appropriate personal #7, and #8), the facility failed to allow unimpeded possessions and clothing On access to shampoo and cream rinse. 09/28/2011 the large bottles of shampoo and conditioner were Findings include: removed from behind the locked door and placed in the outer On 9/27/11 from 5:10am until 8:10am, observation closet fully accessible to each of and interviews were completed at the group home the women in the home. Staff in with clients #1, #2, #3, #4, #6, #7, and #8. On the home received verbal training 9/27/11 at 5:37am, client #1 entered the from the Residential Manager medication closet, and handed a bottle of shampoo regarding the right of each of the and cream rinse to DCS (Direct Care Staff) #1. women to have full access to DCS #1 unlocked the medication closet and placed personal care products. All staff the two bottles on the top shelf inside the locked will be formally trained regarding medication closet. At 5:37am, DCS #1 stated she the right of each of the women to was "unsure" why the shampoo and cream rinse have full access to personal care were kept in the locked closet. At 5:50am, DCS products by October 10, 2011. To #1 indicated the big bottles of shampoo and cream ensure this deficiency does not rinse were kept inside the locked medication room. occur again, the Residential DCS #1 indicated clients #1, #2, #3, #4, #6, #7, Manager, QDP and Residential and #8 had smaller bottles each client refilled from Coordinator will monitor the the large supply bottle. At 6am, clients #6 and #7 availability of personal

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SZLC11

Facility ID:

000906

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G392		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  09/30/2011		
	ROVIDER OR SUPPLIER AL SERVICES INC (		p. whee	STREET A	DDRESS, CITY, STATE, ZIP CODE ST MAIN ST LAKE, IN46982		
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	(X5) COMPLETION
TAG	stated they "ask staff they did not have shall they did not have shall they did not have shall completed. The RC (Qualified Mental R completed. The RC #1, #2, #3, #4, #6, # identified need for the supplies.  Client #1's record was 11:30am. Client #1' Support Plan) and residentified need for some client #2's records was 1:20pm. Client #2's not indicate an ident personal items.  Client #3's records was 10:45am. Client #3' not indicate an ident personal items.  Client #4's record was 12:20pm. Client #4'	ESC IDENTIFYING INFORMATION)  Proof for shampoo and indicated ampoo or cream rinse.  In am, an interview with the RC mator) and the QMRP etardation Professional) was and QMRP indicated clients 7, and #8 did not have an me secured personal care  In as reviewed on 9/27/11 at 86/2/11 ISP (Individual ecord did not indicate an ecured personal items.  In a secured personal items.  In a secured personal items are reviewed on 9/28/11 at 5/11/11 ISP and record did iffied need for secured  In a secured personal items are reviewed on 9/27/11 at 8/4/11 ISP and record did iffied need for secured  In a secured personal items are reviewed on 9/27/11 at 8/4/11 ISP and record did iffied need for secured		TAG	possessions and specifically personal care products. (see attachment A) Residential Manager, QDP and Resident Coordinator responsible.		DATE
W0149	written policies and	evelop and implement d procedures that prohibit ect or abuse of the client.	W	0149	W149 The facility must devel		10/03/2011
	Based on observa	ntion, record review, and			and implement written policie and procedures that prohibit	es	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G392 09/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 308 WEST MAIN ST CARDINAL SERVICES INC OF INDIANA SILVER LAKE, IN46982 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE mistreatment, neglect or abuse of interview, the facility neglected to follow the client. Client #5's their policy and procedures for 1 of 2 Self-Management Plan was clients (client #5) who demonstrated revised to better define PICA and PICA (eating inedible items) behavior. to clarify the level of staff supervision and interventions. The facility neglected to provide sufficient (see attachment B) On supervision of client #5 to prevent the 09/28/2011 a tracking sheet identified PICA behavior and neglected to noting specific PICA behavior and implement effective action to address the requiring that staff document PICA behavior indested items was created. (see attachment C) On 09/28/2011 staff in the group home was Based on observation, record review, and trained on the amended plan and interview, the facility neglected to follow the additional tracking sheet. (see their policy and procedures for 8 of 8 attachments B and C) On 10/03/2011 staff in the facility clients (clients #1, #2, #3, #4, #5, #6, #7, based Day Program were trained and #8) who lived in the group home, to on the amended plan and immediately report client #1's unknown additional tracking sheet. (see attachment D). On 09/28/2011 bruises identified on 9/26/11 and to group home staff was retrained develop interventions to protect clients on Cardinal Services Inc. #1, #2, #3, #4, #5, #6, #7, and #8 from Incident/Abuse/Neglect Policy client #3 and #8's potential for physical which contains the guidelines for aggression. incident reporting.(see attachment E). The Residential Manager and group home staff Findings include: will be trained specifically on reporting injuries of unknown 1. On 9/26/11 at 11:20am, a review of the origin by October 10, 2011. On 09/27/2011 group home staff facility's Bureau of Developmental were alerted to notify the Adult Disability Services (BDDS) reports from Services Director of all significant 10/1/10 through 9/26/11 was completed events such as falls, medication and indicated one (1) report for client #5's errors and injuries. (see attachment F) On PICA behavior: 09/28/2011 Client #8's IDT -An 8/30/11 BDDS report, for an incident amended Client #8's support plan on 8/30/11 at 8:30am indicated client #5 to include that "If peer enters the ingested two (2) "metal tags" and (bed)room assigned staff will remain with (Client #8) to ensure "scratched (her) teeth." The report

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
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CARDIN	AL SERVICES INC	OF INDIANA		1	LAKE, IN46982		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
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		#5 was seen at the local			that monitoring plan is follov Staff will stay in the bedroor		
	medical clinic.				(Client #8) and her roomma		
					until Client #8 is asleep. On		
	On 9/27/11 at 9:35am, an interview with				Client # 8 is asleep staff will		
	the House Manager was completed. The				continue to complete 10 mir		
	House Manager	indicated the medical			bed checks to ensure for the	9	
	clinic said to watch client #5 for distress				safety of Client #4. (see	1.4	
	and to monitor client #5's bowel				attachment G) On 09/30/20 Client #8's Self-Managemer		
	movements.				Plan was amended to reflect		
					IDT recommendations. (see		
					attachment G) Additionally,		
	During observation at the facility owned				09/30/2011 group home stat		
	day service on 9/28/11 from 12:15pm				were retrained on Client #8'		
	until 1:10pm, cli	ent #5 was observed to sit			Self-Management Plan to cl		
	on the floor in th	ne program room, licked a			that staff will redirect Client		
	magazine, chew	ed on the corners of the			move to a different area who will not be bothered by the r		
	pages of a magar	zine, licked her nose with			and start an activity that I		
	1	ed lint from the floor and			enjoy" (see attachment H) T		
	1	nt #5 was not observed to			IDT reviewed Client #3's		
		ch time by facility staff.			Self-Management Plan,		
	be redirected each	on time by facility starr.			particularly interventions		
	0:: 0/26/11 -4.6:				strategies for Client #3's phy		
	1 ^	om, client #5's 10/2010			aggression and self-injuriou behavior and the use of a H		
	`	gement Plan) was			Rights Committee approved		
	1	group home. Client #5's			support hold for the protection		
	SMP indicated s	he had a targeted			Client #3 and Clients #1,#2,		
	behavior of "PIC	CA-This occurs when I am			#5, #6, #7 and #8. The IDT		
	eating items that	are not food ex.			determined that Client #3 ha		
	(example) shoe s	strings and clothing tags.			need for ongoing behavioral intervention as well as		
	1 ' ' '	licked floors, windows,			psychotropic medications ar	nd has	
	walls, or tables while out in the				a history that indicates an o		
	community. I will also take food out of				improvement in functioning		
	the trash can. If staff tries to intervene				this current plan in place. Th	ne use	
	when I am doing these things, I may				of an occasional, short dura		
	1				hold after all other interventi		
		ve." Client #5's SMP			have been attempted has pu		
	indicated "staff will attempt to provide me				to be effective to prevent ha	וווו נט	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G392 09/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 308 WEST MAIN ST CARDINAL SERVICES INC OF INDIANA SILVER LAKE, IN46982 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Client #3 as well as Clients #1. with needed comfort and nurturing by #2. #4. #5. #6. #7 and #8. and is using other, more acceptable activities" to appropriate to continue. The IDT prevent PICA. Client #5's SMP did not determined that no changes indicate the level of supervision staff were should be made to Client #3's plan at this time. (see to provide. attachment I) Group home staff received specific training on the On 9/27/11 at 11:45am, client #5's use of the approved support hold "Behavior Tracking Sheet" was reviewed by reviewing the Cardinal and indicated the following totals for Services Inc. Self-Management Policy (attachemnt J) and Client incidents of PICA behavior: 8/2011--15, #3's Self-Management Plan 7/2011--20, 6/2011--23, 5/2011--45, (attachment K)on 09/27/2011. 4/2011--34, and 3/2011--31. Client #5's The QDP also provided physical "Behavior Tracking Sheet" neglected to demonstration of the support hold to all group home staff on indicate what items client #5 ingested. 09/27/2011 (see attachment L). To ensure this deficiency does not On 9/27/11 at 11:45am, client #5's 9/2/11 occur again, the Residential Manager, QMRP and Residential "Psychiatric Medication Review" was Coordinator will monitor the reviewed. Client #5's Psychiatric Review implementation of all signed by her psychiatrist indicated the individualized plans through daily, following PICA incidents: "2010-2011 weekly, monthly and quarterly Primary Targeted Behaviors...PICA" written observations. QDP, Residential Manager and 7/2011--49, 6/2011--62, 5/2011--41, **Residential Coordinator** 4/2011--128, 3/2011--31, 2/2011--25, Responsible. 1/2011--28, 12/2010--2, 11/2010--8, and 10/2010--7. The Psychiatric Medication Review neglected to indicate what items client #5 ingested. On 9/28/11 at 1:15pm, the QMRP (Qualified Mental Retardation Professional) and the Residential Coordinator (RC) provided an additional undated "Psychiatric Medication Review/Addendum" and stated "this

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			CLIA (X2)	MULTIPLE CO	NSTRUCTION		(X3) DATE S	URVEY
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		ewly revised totals" for						
	client #5's PICA behavior. The QMRP							
	stated she "reviewed the totals" from the							
	· ·	g sheet and psychiatri	c					
		w and "changed the						
		sed form indicated th						
	following: "2010	0-2011 Primary Targe	eted					
	BehaviorsPICA	A" 8/201115, 7/2011	l-					
	-20, 6/201162,	5/201141, 4/2011	128,					
	3/2011 31, 2/20	011 25, 1/201128,						
	12/20102, 11/20108, and 10/20107.							
	The undated form indicated client #5 had							
	a "major PICA occurrence 8/31/2011, she							
	-	s from electronic devi						
	_	nues to be under close	l l					
		to daily attempts to g						
		ems. PICA has contir	l l					
		esented daily[Client						
		d at all times to preve	<b>I</b>					
		nd inedibles that she						
	-	ss. Behaviors are						
	_	ensity. She has a histo	ory					
	of eating glass, s	,	,					
		." The revised undate	<b>I</b>					
		ication Review neglec	eted					
		items client #5 had						
	ingested.							
	On 9/27/11 at 9:3	35am, an interview w	ith					
		Coordinator (RC) and	l l					
		(HM) was completed						
	_	•						
	The RC and the HM both indicated client							
	#5 should have been supervised to protect her from eating inedibles. The RC							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Ev	vent ID: SZLC	11 Facility I	D: 000906	If continuation sh	eet Pag	e 14 of 41

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CO	NSTRUCTION		(X3) DATE COMPI	
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1110		#5 ingested the metal tags		1110				Ditte
		the local medical clinic.						
		ne staff "neglected to						
	-	#5 when the staff knew eat items which were not						
	meant for consum	-						
		not know why client #5's						
		ing Sheets" and the						
	"Psychiatric Med							
		or PICA behaviors did not						
	match. The RC s							
	•	ew" document. The RC						
		ld not identify the specific						
		ems client #5 ingested						
		rear. The RC indicated no						
	other BDDS repo	orts were available for						
	review.							
	The facility's 4/1	•						
		Resolution of Abuse,						
	-	streatment of Individuals						
	was reviewed on	9/26/11 at 12pm, and						
	indicated "[The	name of the Agency] is						
	committed to ens	suring the safety, dignity,						
	and protection of	f persons						
		Incidents involving						
	_	which could be construed						
	as neglectdepri	iving a person served of						
	necessary suppor							
	J 11							
	On 9/26/11 at 12	noon, a review was						
	completed of the							
		Disability Services Policy						
	•	dated 10/05. The BDDS						
FORM CMS-2	567(02-99) Previous Versio		 LC11	Facility I	D: 000906	If continuation sl	neet Pa	ge 15 of 41

	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL	TIPLE CON	NSTRUCTION		(X3) DATE	
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	AL SERVICES INC					LAKE, IN46982			
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TAG			· · · · · · · · · · · · · · · · · · ·		TAG	DEFIC			DATE
		"Neglect, the failure	ιο						
		dual's nutritional,							
		cal, or health needs							
	_	of such support are							
		ered and such failur							
	1 2	al or psychological h	narm						
	to the individual.								
	• • • • • • • • • • • • • • • • • • • •	11.00	0.1						
		11:20am, a review	of the						
	•	of Developmental	_						
	Disability Services (BDDS) reports from 10/1/10 through 9/26/11 was completed								
	_	•							
		did not indicate a re	port						
	for a left hand br	uise.							
	0.006/11	2.45							
		3:45pm until 6:10p							
		served to have a brui							
		ich covered her lowe							
	_	iddle finger and hand							
		7/11 from 5:10am u							
		l was observed at the							
	group home and	had a bruise on her	left						
	hand which cove	ered her lower portio	n of						
	her middle finger	r and hand knuckle.	At						
	5:37am, DCS (D	irect Care Staff) #1							
	administered clie	ent #1's medications.	The						
	surveyor asked c	lient #1 about a brui	se on						
		DCS #1 stated "Sh							
	on it over the we	ekend, didn't you [c	lient						
		stated "I sat on it and							
	_	ed client #1's bruise							
		green." DCS #1 sta							
	client #1's hand b	-							
		four (4") inches from	n the						
FORM CMS-2	567(02-99) Previous Version			LC11	Facility II	D: 000906	If continuation sh	neet Pa	ge 16 of 41

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G392	(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 09/30/2	LETED
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mo	<b>+</b>	's middle finger and		I/IO			DAIL
	the RC and the H RC and the HM bruise had not be administrator or no report was ava	B5am, an interview with IM was completed. The both indicated client #1's een reported to the to BDDS. Both indicated ailable for review. Both #1's hand injury should ed immediately.					
	facility's Bureau Disability Servic through 9/26/11	11:20am, a review of the of Developmental es reports from 10/1/10 was completed and owing for client to client ssive behaviors.					
	-On 7/24/11 at 4pm, client #3 was "frustrated with a peer" and attempted to bite and hit staff and unidentified peers. Staff applied a physical support hold and no injury was reported.						
	biting herself and aggressive. Staff	30pm, client #3 was d was physically f applied a physical no injury was reported.					
	physically aggree Staff applied a tv	45pm, client #3 was ssive "toward others." wo person physical no injury was reported.					

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	AL SERVICES INC			<u> </u>	LAKE, IN46982		
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IAU	-On 7/12/11 at 9 nude, exited the physically aggre physical support reported.  -On 6/11/11 at 10 "obsessive over a from the group he Staff applied a p no injury was reported.  -On 5/17/11 at 8 "frustrated" and bedding. The war and client #3 bed aggressive. Staff support hold and her clothing, exit and became physical person lift back injury was reported.	230am, client #3 was bathroom, and became ssive. Staff applied a hold and no injury was a peer" and left AWOL ame "toward the road." hysical support hold and ported.  230am, client #3 was wanted to wash her asher was in operation came physically f applied a physical I no injury was reported.  215am, client #3 soiled ted the bathroom nude, sically aggressive. Staff all support hold and a two to the bathroom and no ted.  220pm, client #3 exited de and became physically f applied a physical I no injury was reported.		IAU			DATE
	uie vaumoom nu	de and became physically					

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA  (X4) ID PREFIX TAG  aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/8/11 at 4pm, client #3 became physical support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became    A. BULLDING   B. WING		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPLE	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA  (X4) ID PREFIX TAG  aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/8/11 at 4pm, client #3 became physically aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became  STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAIN ST SILVER LAKE, IN46982  ID PROVIDERS PLANGE CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETION DATE  ON 3/8/11 at 4pm, client #3 became physically aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became								
CARDINAL SERVICES INC OF INDIANA  (X4) ID  PREFIX  TAG  CEACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/8/11 at 4pm, client #3 became physicall support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became				B. WIN		ADDRESS CITY STATE ZIPCODE		
(X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/8/11 at 4pm, client #3 became physicall support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became	NAME OF I	PROVIDER OR SUPPLIER			1			
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/8/11 at 4pm, client #3 became physicall support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became	CARDIN	AL SERVICES INC	OF INDIANA		1			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/8/11 at 4pm, client #3 became physically aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became								
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support hold and no injury was reported.  -On 3/8/11 at 4pm, client #3 became physically aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became	IAG	•		+	IAG	DEFECT.)		DATE
-On 3/8/11 at 4pm, client #3 became physically aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became		""						
physically aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became		support nota and	no injury was reported.					
physically aggressive. Staff applied a physical support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became		-On 3/8/11 at 4pr	n. client #3 became					
physical support hold and no injury was reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became		1						
reported.  -On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became		1	* *					
-On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became		1	<i>y y</i>					
"obsessive over peer" and became		^						
		-On 3/2/11 at 8pi						
0.00 1:1		"obsessive over p						
aggressive with peer. Staff applied a		aggressive with p	peer. Staff applied a					
physical support hold and no injury was		physical support	hold and no injury was					
reported.		reported.						
-On 1/23/11 at 4:35pm, client #3		-On 1/23/11 at 4:	35pm, client #3					
"attempted to bite [client #1]." Staff		"attempted to bit	e [client #1]." Staff					
applied a physical support hold and no		applied a physica	al support hold and no					
injury was reported.		injury was report	red.					
-On 7/18/11 at 7:45pm, clients #4 and #8		On 7/19/11 of 7:	15nm aliants #1 and #9					
were inside their shared bedroom which			1 ,					
had a audio monitor in operation. The report indicated staff heard noises from		1	_					
the audio monitor, went to client #4 and		1 ^						
#8's shared bedroom, and client #8 was								
standing over client #4 who was sitting		1						
upright in her bed rubbing one of her		1	· ·					
arms. The report indicated at 8:30am on		1 ^ ~	•					
7/19/11 client #4 had "two (2) bruises" on		1						
her right arm and one bruise on client #4's			` '					
left arm. The report indicated client #4's		T -						
had three bruises and each bruise		1						
measured "2" x 3" (two inches by three								
inches)." The report indicated a		1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G392	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE: COMPL 09/30/2	ETED
NAME OF PROVIDER OR SUPPLIES  CARDINAL SERVICES INC			STREET A	DDRESS, CITY, STATE, ZIP CODE ST MAIN ST LAKE, IN46982	1	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
recommendation (Interdisciplinar every ten (10) m	y Team) for "bed checks					
the RC and the H RC and the HM had "long standi behaviors." The indicated clients verbal skills. Th we have a audio The HM stated w heard the noises shared bedroom, to inquire, and st from the bedroom before client #4 stated the staff "s that night." The had injuries to be morning from cl aggression. The client #3 "would other clients "if applied the phys #3's physically a	On 9/27/11 at 9:35am, an interview with the RC and the HM was completed. The RC and the HM stated clients #3 and #8 had "long standing physically aggressive behaviors." The HM and RC both indicated clients #4 and #8 had limited verbal skills. The HM stated "That's why we have a audio monitor in her bedroom." The HM stated when the staff on duty heard the noises in client #4 and #8's shared bedroom, staff went immediately to inquire, and staff removed client #4 from the bedroom for "about an hour" before client #4 returned to bed. The HM stated the staff "said there was no injury that night." The HM indicated client #4 had injuries to both arms the next morning from client #8's physical aggression. The RC and HM indicated client #3 "would have gotten a hold" of other clients "if staff would not have applied the physical holds" during client #3's physically aggressive behaviors.					
client #8 threw h room hitting the picked up her pu repeatedly, and n	ser purse across the living walls and the furniture, rse, threw the purse again to redirection was 5:15pm until 5:25pm,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SZLC11 Facility ID:

ID: 000906

If continuation sheet

Page 20 of 41

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:			MULTIPLE CO	(X3) DATE			
AND PLAN	OF CORRECTION		А. В	BUILDING	00		COMPL	
		15G392	B. W	VING			09/30/2	UII
NAME OF I	PROVIDER OR SUPPLIEF	R			DDRESS, CITY, STA	ATE, ZIP CODE		
CVDDIVI	AL SERVICES INC	OE INDIANA		I	ST MAIN ST LAKE, IN46982	)		
					LANE, IN40902	<u>-</u>		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	,	ID PREFIX		PLAN OF CORRECTION VE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	NCY MUST BE PERCEDED BY FUL R LSC IDENTIFYING INFORMATIO	I	TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT FICIENCY)	E	DATE
1710	<b>†</b>	ally hit the living room	14)	mo				DATE
	1	ner hands and a thump						
		be heard. From 5:15pm						
		ient #8 was observed by						
	1 .	f (DCS) #3 and no						
	1	observed for client #8's						
		essive behaviors. At						
	_	3 stated "she's (client #8)	,					
		no redirection for client #8	·					
	was observed.							
	The facility's 4/10 Policy for the							
	Prevention and Resolution of Abuse,							
	Prevention and Resolution of Abuse, Neglect, and Mistreatment of Individuals							
	_							
		n 9/26/11 at 12pm, and						
	_	name of the Agency] is						
		suring the safety, dignity,	· [					
	1 ^	f persons served. To						
		ical, mental, sexual abuse	,					
	1 0 , 1	pitation of persons served	_					
	1 *	rs, other persons served, o						
		e tolerated, incidents will						
	_	thoroughly investigated.	,					
		l obligates [Facility name	]					
	1 ^	Bureau of Developmental						
		vices/BDDS and Adult						
		ces (APS) any suspicion						
	_	neglect or abuse whether						
	1	allegation is based upon						
		agency may not screen						
	_	Physical abuse/sexual						
	_	d, alleged, or confirmed						
		al abuse of a person						
	served. This inc	eludes: forced physical						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event II	D: SZLC	11 Facility I	D: 000906	If continuation sh	eet Pa	ge 21 of 41

		X1) PROVIDER/SUPPLIER/CLIA	(X2)	) MULTIPLE CO			(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	А. В	BUILDING	00		COMPL	
		15G392	B. V	VING			09/30/2	U11
NAME OF F	PROVIDER OR SUPPLIER	*		STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
					ST MAIN ST	_		
CARDIN	AL SERVICES INC	OF INDIANA		SILVER	LAKE, IN46982	2		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIATI	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	)	TAG	DEF	FICIENCY)		DATE
	•	infliction of injury, by						
	G. 1	, or kicking, physical						
	restraints, using p	•						
		l harm or painNeglect:						
		ing persons served which						
		ed as neglectdepriving a						
	-	necessary supportThe						
		nust always report all						
		liately to an on call						
	supervisor. That	t supervisor will report all						
	incidents to the D	Department Coordinator						
	for further follow							
	unknown origin and allegations of abuse,							
	neglect, and mist	treatment must be						
	reported to the A	dministrator						
	immediately."							
	,							
	On 9/26/11 at 12	2noon, a review was						
	completed of the							
	•	Disability Services Policy						
	•	dated 10/05. The BDDS						
	· ·	edure indicated "Abuse,						
	Neglect, and Mis							
		s the policy of the						
		are that individuals are not						
	1 2	sical, verbal, sexual, or						
		buse by anyone including						
		o facility staffother						
		nemselves." The policy						
	_	ect, the failure to supply						
		utritional, emotional,						
	* *	th needs although sources						
		are available and offered						
	and such failure	results in physical or						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	SZLC	11 Facility I	D: 000906	If continuation sh	eet Pa	ge 22 of 41

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED				
		15G392	B. WIN			09/30/2	011
	PROVIDER OR SUPPLIER  AL SERVICES INC (			STREET A	ADDRESS, CITY, STATE, ZIP CODE EST MAIN ST R LAKE, IN46982		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	psychological harm to the individual."  9-3-2(a)  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported			TAG	DEFICIENCY		DATE
W0153	mistreatment, neglinjuries of unknown immediately to the officials in accordate established proced.  Based on observation interview, for 1 of 1 (client #1), the facilic client #1's hand bruited by BDDS (Bureau of Developments) in accordate in accordate in a services in accordate in acc	dect or abuse, as well as a source, are reported administrator or to other since with State law through dures.  In, record review, and unknown injury observed ty failed to immediately report se to the administrator and to revelopmental Disability nice with state law.  In am, a review of the facility's mental Disability Services of through 9/26/11 was #1 and did not indicate a	W	0153	w153 The facility must ensuthat all allegations of mistreatment, neglect or abuse as well as injuries of unknow source, are reported immediato the administrator or to other officials in accordance with Slaw through established procedures. Cardinal Service Inc. is committed to providing quality services and a safe environment free from abuse neglect and mistreatment for people that we provide supporter. Cardinal Services, Inc. ensures that staff are trained regarding the prevention of a and neglect and the incident reporting guidelines by provide "Prevention of Abuse and Neglect" foundations training during the new hire process. addition to this, Cardinal Services, Inc. staff receive a training regarding abuse prevention along with annual review of the	se, n ately er state ces, the orts ding In	10/10/2011

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL 14 (Fig. 1) (Fig. 1) (Fig. 1) (Fig. 2) (Fig. 1) (Fig. 2) (Fig.	STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			SURVEY
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  client's hand. DCS #1 stated "She sat on it over the weekend, didn't you [client #1]?" Client #1 stated "I sat on it and did it." DCS #1 stated client #1's hand bruise was "approximately four (4") inches from the hand up client #1's middle finger and about three (3") inches wide."  On 9/27/11 at 9:35am, an interview with the RC and the HM was completed. The RC and the HM was completed. The RC and the HM was completed. The RC and the HM both indicated client #1's bruise had not been reported. Both indicated client #1's hand injury should have been reported immediately.  9-3-2(a)  STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAIN ST SILVER LAKE, IN46982  (X5)  PROVIDERS ILANG CORRECTION (X5)  COMPLETION DATE  Incident/Abuse/Neglect policy. Group home staff were re-trained on the Incidents of abuse/neglect/mistreatment and unknown origin to the administrator immediately. All 14 West staff were re-trained on Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 09/27/2011 (see attachment E) On 09/27/2011 (group home staff were alerted to notify the Adult Services Director of all significant events such as falls, medication errors and injuries. (see attachment F)14 West staff will	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DINC	00	COMPL	ETED
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CARDINAL SERVICES INC OF INDIANA   SILVER LAKE, IN46982	NAME OF F	PROVIDER OR SUPPLIER	8					
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF CORRECTION (X5)	OADDIN	AL 055 //050 INO	OF INIDIANIA					
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9-3-2(a)  Services Director of all significant events such as falls, medication errors and injuries. (see attachment F)14 West staff will		1				• •		
errors and injuries. (see attachment F)14 West staff will		should have been reported immediately.				Services Director of all signif	icant	
attachment F)14 West staff will		9-3-2(a)					tion	
		9-3-2(a)						
						•	vill	
						be required to demonstrate		
competency regarding incident							ent	
reporting by completing an								
Incident Reporting Quiz by 10/10/2011. The QMRP,								
Residential Manager and								
Residential Coordinator will						_		
continue to monitor the treatment							ment	
of persons served through								
weekly, monthly and quarterly							v	
observations to ensure this							,	
deficiency does not occur again in								
the future. QMRP, Residential							tial	
Manager and Residential						•		
Coordinator Responsible.						Coordinator Responsible.		
	W0157							
corrective action must be taken.		corrective action r	nust be taken.					
$\begin{array}{ c c c c c c c c c c c c c c c c c c c$				W	0157			10/03/2011
Based on observation, record review, and verified, appropriate corrective		Based on observation	on, record review, and					
action must be taken. Olient #5.5							#5 <sup>*</sup> S	
continuing emont and was						•	and	
demonstrated PICA (eating inedible items)  revised to better define PICA and to clarify the level of staff							anu	
behavior. supervision and interventions.			· · · · · · · · · · · · · · · · · · ·				s.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G392 09/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 308 WEST MAIN ST CARDINAL SERVICES INC OF INDIANA SILVER LAKE, IN46982 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (see attachment B) On 09/28/2011 a tracking sheet Findings include: noting specific PICA behavior and requiring that staff document On 9/26/11 at 11:20am, a review of the facility's ingested items was created. (see Bureau of Developmental Disability Services attachment C) On 09/28/2011 (BDDS) reports from 10/1/10 through 9/26/11 was staff in the group home was completed and indicated one (1) report for client trained on the amended plan and #5's PICA behavior: the additional tracking sheet. (see -An 8/30/11 BDDS report, for an incident on attachments B and C) On 8/30/11 at 8:30am indicated client #5 ingested two 10/03/2011 staff in the facility (2) "metal tags" and "scratched (her) teeth." The based Day Program were trained report indicated client #5 was seen at the local on the amended plan and medical clinic. additional tracking sheet. (see attachment D). The QDP will use On 9/27/11 at 9:35am, an interview with the House the specific PICA data collected Manager was completed. The House Manager to report ingested items to Client indicated the medical clinic said to watch client #5 #5's Psychiatrist on the for distress and to monitor client #5's bowel Psychiatric Medication Review movements. form. (see attachment M) To ensure this deficiency does not During observation at the facility owned day occur again, the Residential service on 9/28/11 from 12:15pm until 1:10pm, Manager, QDP and Residential client #5 was observed to sit on the floor in the Coordinator will monitor the program room, licked a magazine, chewed on the implementation of all corners of the pages of a magazine, licked her nose individualized plans through daily, with her tongue, picked lint from the floor and ate weekly, monthly and quarterly the lint. Client #5 was not observed to be written observations. The Support redirected each time by facility staff. Services Coordinator and Nurse will ensure that all applicable data On 9/26/11 at 6pm, client #5's 10/2010 SMP (Self is correctly entered on the **Psychiatric Medication Review** Management Plan) was reviewed at the group form through review of home. Client #5's SMP indicated she had a documents. Support Services targeted behavior of "PICA-This occurs when I am Coordinator, Residential Nurse, eating items that are not food ex. (example) shoe QDP, Residential Manager and strings and clothing tags. At times I have licked **Residential Coordinator** floors, windows, walls, or tables while out in the Responsible community. I will also take food out of the trash can. If staff tries to intervene when I am doing these things, I may become aggressive." Client #5's SMP indicated "staff will attempt to provide

STATEMEN	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPLE	TED
		15G392	B. WIN			09/30/20	11
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
				1	EST MAIN ST		
CARDINA	AL SERVICES INC	OF INDIANA		SILVER	LAKE, IN46982		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	<sub></sub>	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	' <sup>-</sup>	DATE
	me with needed con	nfort and nurturing by using	İ				
		ble activities" to prevent PICA.					
		not indicate the level of					
	supervision staff we						
	1	1					
	On 9/27/11 at 11:45	am, client #5's "Behavior					
		s reviewed and indicated the					
		incidents of PICA behavior:					
	_	-20, 6/201123, 5/201145,					
		01131. Client #5's "Behavior					
	Tracking Sheet" neglected to indicate what items						
	client #5 ingested.						
	On 9/27/11 at 11:45am, client #5's 9/2/11						
	"Psychiatric Medication Review" was reviewed.						
	-	ric Review signed by her					
	-	d the following PICA					
		011 Primary Targeted					
		7/201149, 6/201162,					
		-128, 3/201131, 2/201125,					
		02, 11/20108, and 10/2010-					
		Medication Review neglected					
		ns client #5 ingested.					
, l		-					
	On 9/28/11 at 1:15p	m, the QMRP (Qualified					
	_	Professional) and the					
		ator (RC) provided an					
		Psychiatric Medication					
		and stated "this documents					
	the newly revised to	tals" for client #5's PICA					
	behavior. The QMF	RP stated she "reviewed the					
	totals" from the beh	avior tracking sheet and					
	psychiatric medicati	on review and "changed the					
		form indicated the following:					
		Targeted BehaviorsPICA"					l
		-20, 6/201162, 5/201141,					
		31, 2/2011 25, 1/2011-					l
, l	· ·	20108, and 10/20107. The					
, l		ted client #5 had a "major					
		31/2011, she ate the metal tags					
		,					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
		15G392	A. BUII B. WIN	LDING IG		09/30/2	011
NAME OF F	PROVIDER OR SUPPLIER	<u>                                     </u>			DDRESS, CITY, STATE, ZIP CODE		
				1	ST MAIN ST		
	AL SERVICES INC			L	LAKE, IN46982		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	from electronic dev	ices. [Client #5] continues to					
		rvation due to daily attempts to					
	-	items. PICA has continued					
		nted daily[Client #5] must be s to prevent access to food and					
		tempts to access. Behaviors					
		ensity. She has a history of					
	_	, and other dangerous items."					
		l Psychiatric Medication					
		o indicate what items client #5					
	had ingested.						
	On 9/27/11 at 9:35a	ım, an interview with the					
		nator (RC) and the House					
	Manager (HM) was completed. The RC and the						
		client #5 should have been					
		et her from eating inedibles.					
		lient #5 ingested the metal tags local medical clinic. The RC					
		lected to supervise" client #5					
		client #5 would eat items					
		ant for consumption. The RC					
	indicated he did not	know why client #5's					
	-	Sheets" and the "Psychiatric					
		" behavior totals for PICA					
		atch. The RC stated "go by iew" document. The RC					
		not identify the specific					
		s client #5 ingested during the					
	past year. The RC	indicated no other BDDS					
	*	ble for review. The RC and the					
		t #5's plan was reviewed and no					
	changes in client #5 review.	's plan were available for					
	TOVICW.						
	9-3-2(a)						
W0318	The facility must e	ensure that specific health					
110310		uirements are met.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DIVI	DDIC	00	COMPL	ETED
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			B. WIN				
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					EST MAIN ST		
	AL SERVICES INC				R LAKE, IN46982		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
			W	0318	W 318 The facility must ensi		10/23/2011
	Danad an abaamatia				that specific health care serv	ices	
	Based on observation, record review, and interview, the Condition of Participation: Health				requirements are met Cardi		
		-			Services, Inc. strives to meet		
		not met as the facility failed to			be in compliance with all of the	ne	
		ealth care monitoring and			conditions of participation		
	_	tion administration for 3 of 8			established by the Secretary		
		3, and #7) with significant			Health and Human Services.	This	
	medication errors.				allegation of compliance is		
		to the property of			intended to show Cardinal		
	_	e resulted in an IMMEDIATE			Services' commitment to qua		
	JEOPARDY. The immediate jeopardy was identified on 9/27/11 at 9:10am. The immediate jeopardy began on 6/28/11 when the facility failed				delivery of services. Proacti		
					strategies and corrective acti		
					will be developed as needed	to	
		oversight, failed to develop			avoid further incidents. It is		
		ons to prevent further			Cardinal Services' belief that	tne	
		and failed to monitor staff			corrective action taken by	<b>D</b> D	
		s. The Agency's Residential			management staff and the Q	DP	
		as notified of the Immediate			has resolved the Immediate		
		1 at 9:10am. The Immediate			Jeopardy created in the full		
	Jeopardy was not re	emoved.			recertification survey dated	4 30	
					September 26, 27, 28, 29 an 2011. The following citations		
	Findings include:				POAs will be monitored by the		
					governing body to ensure fol		
		1. The facility's nursing			up and compliance is in place		
	_	ovide adequate health care			Please refer to W331 Please		
	monitoring and over				refer to W368 Please refer to		
		of 8 clients (clients #1, #3,			W382	<b>-</b>	
	and #7) with signific	cant medication errors.					
	Please refer to W26	8. The facility staff failed to					
		ons according to physician					
		ents (clients #1, #3, and #7)					
	with significant med						
	with significant filet	aicanon chors.					
	Please refer to W38	2. The facility failed to					
		dication security for 1 of 1					
	* *	th a personal medication box.					
	(eneme " / ) WI	F 31001ml Invalounon 00/1.					
	9-3-6(a)						
	()						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G392 09/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 308 WEST MAIN ST CARDINAL SERVICES INC OF INDIANA SILVER LAKE, IN46982 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must provide clients with nursing W0331 services in accordance with their needs. W331 The facility must provide W0331 10/23/2011 clients with nursing services in Based on observation, record review, and accordance with their needs. In interview, the facility's nursing services failed to order to assure that specific, provide adequate health care monitoring and accurate communication occurs oversight of medication administration for 3 of 8 between the nurse and the clients (clients #1, #3, and #7) with significant physician when a medication medication errors. error is committed the Medication Error Report form will be revised Findings include: to include fields for the exact follow up recommendations from On 9/26/11 at 11:20am, a review of the facility's the prescribing physician by Bureau of Developmental Disability Services 10/10/2011. Nurses will be trained reports from 10/1/10 through 9/26/11 was on the form revisions by completed and indicated the following for client 10/10/2011. In order to assure #1, #3, and #7's medications given in error: that Direct Support Professionals are informed of the prescribing For client #1: physician's recommendations -On 8/19/11 at 1pm, client #1 "was given a peer's" when a medication error has medication of Lamictal 200mg (milligrams) for been committed and accurate seizures, Felbatol 600mg for seizures, and monitoring occurs, a Client Depakote 500mg for seizures. The report Medication Error Follow indicated staff were to "monitor" client #1. Up/Results form will be created -On 8/19/11 at 8:45pm, client #1 became unsteady by 10/10/2011. This form will and fell. The report indicated client #1 had two include fields for the name of the (2) bruises on her left knee and four (4) bruises on person served, the exact medication error, the her left thigh. recommendations/follow along orders from the prescribing -On 6/28/11 at 6am, client #1 was given "2 (two) physician, monitoring results and doses of Enablex 7.5mg" for blood pressure. The any noted adverse effects. This report indicated staff were to monitor client #1. form will be reviewed as needed and monthly by the Nurse and For client #3: then filed in the person served -On 8/19/11 at 12:40pm, client #3 received a main file. The form will be trained "second dose of Klonopin 0.5mg after meds on and implemented by (medications) were already passed." The report 10/23/2011. In order to ensure indicated staff were to monitor client #3. that staff are provided with adequate equipment to monitor For client #7: blood pressure for Clients #1, #2,

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G392		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE S COMPL 09/30/2	ETED	
		13G392	B. WIN			09/30/2	011
NAME OF	PROVIDER OR SUPPLIEF	8		308 WE	ADDRESS, CITY, STATE, ZIP CODE EST MAIN ST		
CARDIN	IAL SERVICES INC	OF INDIANA		SILVER	LAKE, IN46982		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Remeron 45mg (for belonging to another staff were to monitor. On 9/27/11 at 6am, #7, and #8's group has used to monitor vita pressure did not ope #8's vital signs. At 9/2011 MAR (Medi Records) were revied Staff) #2 and the Hoon 9/26/11 that "no and clients #4 and #4 able to be complete. Client #1's record with 11:30am. Client #1 monthly nurses note medication errors. Order" indicated "Expressure) take one to "Depakote 250mg to tablet by mouth three fam, 1pm, and 8pm tablet P. O. (orally) #1's record did not in monitored after the medication was given evidence was availad medical record regal errors, nursing mon adverse effects.  Client #3's record with 10:45am. Client #3 nurses notes did not medication error. Or did not medication error.	m, client #7 was "given or organic mood disorder) or client." The report indicated or client #7's blood pressure.  clients #1, #2, #3, #4, #5, #6, nome blood pressure machine al signs which included blood erate to monitor clients #4 and 12:30pm, clients #4 and #8's ication Administration ewed and DCS (Direct Care buse Manager both documented batteries (were) in B/P cuff" e8's blood pressures were not d.  was reviewed on 9/27/11 at 's 9/2011, 8/2011, and 6/2011 es did not indicate client #1 had Client #1's 7/25/11 "Physician's mablex 7.5mg (for blood ablet once daily at 7am" and ablet (for seizures) take one et times daily with 500mg at an in the am (morning)" Client indicate her blood pressure was additional blood pressure en in error. No documented able for review in client #1's arding client #1's medication itoring, nursing follow up, or was reviewed on 9/27/11 at 's 9/2011 and 8/2011 monthly indicate client #3 had a Client #3's 8/4/11 "Physician's Elonopin 1mg take 1 tablet by			#3, #4, #5, #6, #7 and #8 the group home will be equipped a manual blood pressure cuf stethoscope by 10/10/2011. order to assure that all people receiving Residential services through Cardinal Services In receive adequate medical supports each group home wequipped with a manual blood pressure cuff and stethoscop 10/10/2011. Ongoing monito will occur to ensure consister implementation through mon document review by the Residential Manager and Su Services Coordinator. Supposervices Coordinator, Nursand Residential Manager Responsible	d with f and In e s c. vill be od pe by ring nt thly pport	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G392 09/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 308 WEST MAIN ST CARDINAL SERVICES INC OF INDIANA SILVER LAKE, IN46982 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE mouth at bed time at 8am (for behaviors)." Client #3's record did not indicate her vital signs were monitored. No documented evidence was available for review in client #3's medical record regarding client #3's medication errors, nursing monitoring, nursing follow up, or adverse effects. Client #7's record was reviewed on 9/27/11 at 12:15pm. Client #7's 9/2011, 8/2011, 7/2011, 6/2011, 5/2011, and 4/2011 monthly nurses notes did not indicate client #7 had medication errors. Client #7's 7/25/11 "Physician's Order" indicated "Calcium W/D (with vitamin D) take 1 tablet by mouth twice daily at 7am and 5pm" for nutritional health. Client #7's record did not indicate a physician's order for Remeron for organic mood disorder. Client #7's record did not indicate her vital signs were monitored. No documented evidence was available for review in client #7's medical record regarding client #7's medication errors, nursing monitoring, nursing follow up, or adverse effects. On 9/26/11 at 1:50pm, and on 9/27/11 at 9:35am, during interviews with the Residential Coordinator (RC), the facility's medication error reports were requested and no medication error reports were available for review. On 9/26/11 at 1:50pm and on 9/27/11 at 9:35am, the RC indicated he would locate the reports. On 9/28/11 at 2:30pm, the RC provided client #1, #3, and #7's "Medication Error Form" which indicated the following: For client #1: -A Medication Error Report on 8/22/11 for an error on 8/19/11 reported at 1:58pm, indicated client #1 "was given a peer's medications" of Lamictal 200mg (milligrams) for seizures, Felbatol 600mg for seizures, and "she was given Depakote

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
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	AL SERVICES INC				LAKE, IN46982		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<del>                                     </del>	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s) that she is to receive." The					
	report indicated "Treatment: Monitor for 24						
	(twenty-four) hours, vitals every 4 (four) hours,						
	and watch for dizzi	ness or nausea." No					
	documented monito	oring was available for review.					
	-A Medication Erro	r Report on 6/28/11 reported at					
	7:15am, indicated c	elient #1 was given "2 (two)					
	doses of Enablex (7	7.5mg) during the med					
	(medication) pas in	stead of one." The report					
	indicated "Were there any adverse effects from the						
	medication error" was blank and "If yes, please						
	describe: not at this time will be monitoring." No						
	documented monitoring was available for review.						
	F 1:						
	For client #3:	D 0/10/11 1 1					
		or Report on 8/19/11 reported at					
	1 ^	"Medication: Clonazepam					
		Lost med or possibly given					
		ented monitoring was available					
	for review.						
	For client #7:						
	-A Medication Erro	or Report on 3/6/11 reported at					
		'Medication: Remeron 45mg."					
		d client #7 was "given					
	1 -	r organic mood disorder)"					
	I .	a different client. No					
	1	oring was available for review.					
	On 9/27/11 at 9:35a	am, the RD and the House					
	Manager were inter	viewed. The RC stated "at					
	1 -	on errors were "significant"					
		The RC and the House					
		eated clients should have had					
	_	nitored after the medication					
	errors.						
	On 9/27/11 at 11:50	Dam, an interview with the Site					
		completed. The SD indicated					
	1 ' '	have documentation the facility					
	"" "" " " " " " " " " " " " " " " " "	Jaconnentation the facility	- 1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY		
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CARDIN	AL SERVICES INC	OF INDIANA		1	LAKE, IN46982			
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(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
		met to discuss medications not						
	_	according to physician orders						
		ing follow up to the incidents.						
		review of an agency internal						
		cumented an overall review of						
		rs. The SD indicated the n errors had decreased over the						
	, ,	"they're mostly at" this group						
	1 ^ -	up home's medication errors are						
		the clients "are at risk"						
		o of the medication errors are						
	significant." The SD indicated the staff and House							
	Manager were responsible for ensuring nursing was notified of the incidents. The SD stated							
	"they're looking for staff training" of corrective							
	action.							
	On 9/28/11 at 2:30p	om, an interview with the						
		sed Practical Nurse), the RC,						
		completed. The RC and LPN						
	1 ^	ed monitoring by the agency						
		rve medication administration						
		on 5/19/11, 3/24/11, 3/4/11,						
		0. The agency LPN and RC						
		olved with the specific as retrained" for medication						
		e RC indicated the agency had						
		g available for staff to						
	1	and agency LPN indicated staff						
	1 ^	four (1-4) for medication						
		ed if staff acquired a score of						
		od of time" the specific staff						
		A/Core B medication						
		ing. The RC and LPN						
		ot consider client #1, #3, and						
	-	ors to have the potential to						
	cause harm. The ag	gency LPN stated she would						
		and #4's medication errors as						
		N provided staff training						
	documents for clien	ts #1, #3, and #4's medication						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CON	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G392	A. BUILI	DING	00	COMPL 09/30/2	
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NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ST MAIN ST		
CARDINA	AL SERVICES INC	OF INDIANA			LAKE, IN46982		
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PREFIX		CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DETICIENC!)		DATE
W0368	providing medication was "human error" to medication errors what administered by the the specific medicate and #7 were reported and "no one went to on 9/30/11 at 2:15p. and #3's "Vital" sign 8/20/11. The LPN is "Vital" sign record is completed for 8/20/19-3-6(a)  The system for drugsure that all drug compliance with the Based on observation interview, the facilit medications according administration of the system for drugsure that all drug compliance with the Based on observation interview, the facilit medications according to the system for drugsure that all drug compliance with the system for drugsure that all drug complits the system for drugsure that all drug compliance with the syst	m, the LPN provided client #1 as completed 8/19/11 and ndicated client #1 and #3's ndicated vital signs were not	W0	368	W368 Cardinal Services has ongoing medication error reduction program. Medicatic errors are tracked for quarter analysis. Agency-wide medic errors have been reduced ov the past two years as noted i	on ly cation er	10/20/2011
	Findings include:				annual safety analysis (see attachment N). The Medication	on	
	On 9/26/11 at 11:20am, a review of the facility's Bureau of Developmental Disability Services reports from 10/1/10 through 9/26/11 was completed and indicated the following for client #1, #3, and #7's medications given in error:  For client #1: -On 8/19/11 at 1pm, client #1 "was given a peer's" medication of Lamictal 200mg (milligrams) for seizures, Felbatol 600mg for seizures, and				Error Workteam created an agency-wide survey pertaining medication errors this year. Environmental, Physical, and Competency factors were all surveyed for each site. Data collected from direct support was placed into site-specific action plans to address these factors. The objective of this survey and action plans is to	staff	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G392 09/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 308 WEST MAIN ST CARDINAL SERVICES INC OF INDIANA SILVER LAKE, IN46982 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Depakote 500mg for seizures. The report eliminate any barriers in a site indicated staff were to "monitor" client #1. that can lead to a medication error.(see attachement O). In -On 8/19/11 at 8:45pm, client #1 became unsteady order to ensure that staff is and fell. The report indicated client #1 had two familiar with medication (2) bruises on her left knee and four (4) bruises on administration procedures group her left thigh. home staff were re-trained on Cardinal Services Inc. Medication -On 6/28/11 at 6am, client #1 was given "2 (two) Policy on 09/27/2011. (see doses of Enablex 7.5mg" for blood pressure. The attachment P) Cardinal Services report indicated staff were to monitor client #1. Inc. Day Program staff were retrained on the Medical Policy on For client #3: 10/03/2011. (see attachment D) -On 8/19/11 at 12:40pm, client #3 received a To assure that group home staff "second dose of Klonopin 0.5mg after meds complete error free medication (medications) were already passed." The report administration staff must indicated staff were to monitor client #3. demonstrate medication administration competency by For client #7: completing two error free -On 3/7/11 at 6:30pm, client #7 was "given medication passes while being Remeron 45mg (for organic mood disorder) observed by a nurse or belonging to another client." The report indicated supervisor. Competency will be staff were to monitor client #7's blood pressure. confirmed through observation by 10/20/2011. Residential Client #1's record was reviewed on 9/27/11 at Manager, Nurse and 11:30am. Client #1's 7/25/11 "Physician's Order" **Residential Coordinator** indicated "Enablex 7.5mg (for blood pressure) responsible. take one tablet once daily at 7am" and "Depakote 250mg tablet (for seizures) take one tablet by mouth three times daily with 500mg at 6am, 1pm, and 8pm, Depakote 500mg take one tablet P. O. (orally) in the am (morning)...." Client #1's record did not indicate her blood pressure was monitored after the additional blood pressure medication was given in error. Client #3's record was reviewed on 9/27/11 at 10:45am. Client #3's 8/4/11 "Physician's Order" indicated "Klonopin 1mg take 1 tablet by mouth at bed time at 8am (for behaviors)." Client #3's record did not indicate her vital signs were

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		INSTRUCTION 00	(X3) DATE S COMPL		
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	PROVIDER OR SUPPLIER  AL SERVICES INC (			308 WE	ADDRESS, CITY, STATE, ZIP CODE EST MAIN ST R LAKE, IN46982		
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	monitored.						
	12:15pm. Client #7' indicated "Calcium" tablet by mouth twice nutritional health. Clindicate a physician' organic mood disord indicate her vital sig documented evidence client #7's medical remedication errors, not follow up, or advers:  On 9/26/11 at 1:50pm during interviews with (RC), the facility's requested and no me available for reviews on 9/27/11 at 9:35am locate the reports.  On 9/28/11 at 2:30pm #3, and #7's "Medication Error error on 8/19/11 reported the following for seizures, 750mg (for seizures, 750mg (for seizures) report indicated "Tre (twenty-four) hours, and watch for dizzin documented monitor-A Medication Error 7:15am, indicated cl	m, and on 9/27/11 at 9:35am, ith the Residential Coordinator redication error reports were edication error reports were. On 9/26/11 at 1:50pm and in, the RC indicated he would m, the RC provided client #1, ation Error Form" which ing:  Report on 8/22/11 for an orted at 1:58pm, indicated a peer's medications" of illigrams) for seizures, Felbatol and "she was given Depakote of that she is to receive." The eatment: Monitor for 24 vitals every 4 (four) hours,					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
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CAPDIN	AL SERVICES INC	OE INDIANA		1	LAKE, IN46982		
CARDIN	AL SERVICES INC	OF INDIANA		SILVEN	LANE, 11140902		
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		stead of one." The report					
		re any adverse effects from the					
		as blank and "If yes, please					
		time will be monitoring." No					
	documented monito	oring was available for review.					
	T 1' 4/10						
	For client #3:	D 0/10/11					
	-A Medication Error Report on 8/19/11 reported at 12:40pm, indicated "Medication: Clonazepam						
	* '	Lost med or possibly given					
	twice." No documented monitoring was available						
	for review.  For client #7:						
		r Report on 3/6/11 reported at					
		Medication: Remeron 45mg."					
		d client #7 was "given					
		organic mood disorder)"					
		a different client. No					
		oring was available for review.					
	On 9/27/11 at 9:35a	m, the RD and the House					
	Manager were inter	viewed. The RC stated "at					
	least two" medication	on errors were "significant"					
	medication errors.	The RC and the House					
	1 -	ated clients should have had					
	their vital signs mor	nitored after the medication					
	errors.						
	0.00=1::						
		am, an interview with the Site					
	` ′	completed. The SD indicated					
	1	nave documentation the facility					
		met to discuss medications not					
	_	according to physician orders					
		review of an agency internal					
		cumented an overall review of					
		rs. The SD indicated the					
		n errors had decreased over the					
		"they're mostly at" this group					
	past year and stated	they ie mostly at this group					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G392		(X2) MU A. BUII B. WIN	DING	NSTRUCTION  00	(X3) DATE COMPI 09/30/2	ETED	
	PROVIDER OR SUPPLIER		B. WIIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST MAIN ST LAKE, IN46982		
	SUMMARY S  (EACH DEFICIENT REGULATORY OR Home and this "grout up." The SD stated because "at least two significant." The SI Manager were responsas notified of the in "they're looking for action.  On 9/28/11 at 2:30 pagency LPN (Licents and the QMRP was provided documented nurse visits to observat the group home of 2/12/11, and 7/22/10 stated "the staff involved medication error was administration. The a web based training complete. The RC a were scored one to find the staff of the staff involved the st			308 WE	ST MAIN ST	ATE	(X5) COMPLETION DATE
	had to repeat Core A administration traini indicated they did no #7's medication error cause harm. The ag score client #1, #3, a "four (4)." The ager error" that clients co errors when medicat facility staff. The L medication errors for reported to their perswent to the hospital.	ng. The RC and LPN of consider client #1, #3, and rs to have the potential to ency LPN stated she would and #4's medication errors as ncy LPN stated it was "human intinued to have medication ions were administered by the PN stated the specific r clients #1, #3, and #7 were sonal physician and "no one " The LPN indicated client lications were not given					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G392	B. WIN			09/30/2	011
NAME OF E	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
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CARDIN	AL SERVICES INC	OF INDIANA		SILVER	R LAKE, IN46982		
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	9-3-6(a)						
W0382	The facility must keep all drugs and biologicals locked except when being prepared for administration.		W	0382	<b>W382</b> The facility must keep		11/03/2011
	Based on observa	ation, record review, and			drugs and biologicals locked		
	interview, for 1 of	of 1 client (client #7) with			except when being prepared administration. In order to en		
	a personal medic	eation box, the facility			that all medications are kept		
	failed to maintain	n proper medication			secure, staff in the group hor	me	
	security.				were retrained on Cardinal Services Inc. Medication Policy		
Findings include:	:			which includes securing medications on 09/27/2011. attachment P) Additionally gi	(see		
	On 9/27/11 from	5:10am until 8:10am,			home staff will be trained specifically on keeping Client #7's		
	observation and	interview were completed			medications secure by	t#/S	
	at the group hom	ne. At 6:50am, client #7			10/10/2011. All Cardinal Ser	vices	
	was observed sit	ting in her wheel chair			staff will be trained on securi	ng	
	outside the medi	cation room and held her			medication by 10/10/2011.	ır to	
	multi dose medic	cation cards Calcium and			Ongoing monitoring will occu ensure that medications are		
	Multivitamin. A	t 6:50am, client #7's			secured through weekly, mo		
		was open with the key in			and quarterly observations b	y the	
		ox was observed on her			Residential Manager, QDP, Residential Nurse and Residential	lential	
		ared bedroom. Client			Coordinator. <b>Residential</b>	cillidi	
		box held multi dose			Manager, QDP, Residential		
	medication cards	s of Calcium with			Nurse and Residential		
	`	nin), Mobic 65mg (for			Coordinator Responsible.		
		y), Acetaminophen					
		or discomfort), Sudafed					
	·	nd Immodium (for					
	· · · · · · · · · · · · · · · · · · ·	6:55am, until 7:05am,					
	client #7 entered	the medication room					
	with Direct Care	Staff (DCS) #1 to					
	complete medica	ation administration. At					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING 00 COMPLETED					
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	AL SERVICES INC				LAKE, IN46982		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION  PD FFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG W0436	7:05am, the Housindicated client #have been secure  An interview was 1:15pm, with age Practical Nurse) of LPN indicated standard	s conducted on 9/28/11 at ency LPN (Licensed was completed. The ated "all" medications when not being  urnish, maintain in good clients to use and to make about the use of dentures, and other ids, braces, and other by the interdisciplinary team client.  un, record review, and sample clients (client #3) who are glasses, the facility failed to client #3 to wear her es.	W	TAG 0436	W436 The facility must furnis maintain in good repair, and teach clients to use and to m informed choices about the udentures, eyeglasses, hearin and other communications ai braces, and other devices identified by the interdisciplin team as needed by the client ensure that Cardinal Services provides proper supports for Client #3, a Desensitazation will be written regarding the use the communication of the communication of the client ensure that Cardinal Services provides proper supports for Client #3, a Desensitazation will be written regarding the use of the communication of the communicat	sh, ake ase of g ds, ary s Inc.	10/10/2011
	medications, read th	ration, punched out her own e menu with staff, watched we glasses were observed			of eye glasses and staff will be trained on the plan by 10/10/ A revised goal will be written trained on and implemented formally offering Client #3	oe 2011.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SZLC11 Facility ID:

000906 If continuation sheet Page 40 of 41

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G392		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 09/30/2	LETED	
	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE EST MAIN ST LAKE, IN46982		
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	Professional) was in 1:15pm. The QMR prescription eye glast client #3 should have to wear her prescriptated client #3 had 8/2011 for client #3 glasses for five (5) so On 9/27/11 at 10:45 reviewed. Client #3 Support Plan) indicate	am, client #3's record was 's 4/4/11 ISP (Individual ted she wore prescription eye 12/7/10 vision exam indicated			prompts to wear her glasse times daily by 10/10/2011. Informally Client #3 will be prompted to wear her glass when reading or watching television. To ensure that the deficiency does not occur in future monitoring will be doweekly, monthly and quarte the Residential Manager, and Residential Coordinator Residential Manager, QDI Residential Coordinator responsible.	ses nis n the one erly by QDP or.	